GroupHealth OPTIONS, INC.

Options Health Plan
Summary of Benefits

Hanford Employee Welfare Trust (HEWT) Represented

Effective Date 1/1/2006 **Ref** 0668135003

This is a brief summary of benefits and limitations. THIS IS NOT A CONTRACT. For a more detailed description of your benefits and exclusions, refer to your certificate of coverage or contact your employer or benefits administrator.

Benefit	Inside Network	Outside Network
Network	When care is provided or referred by the Managed Health Care Network (MHCN). **Benefit allowances utilized inside the Network cannot be duplicated outside the Network.**	When care is not provided by or referred by the Managed Health Care Network. **Benefit allowances utilized outside the Network cannot be duplicated inside the Network.**
Hospital Admission Certification	Not required.	All scheduled inpatient hospital admissions must be authorized by GHO at least seventy-two (72) hours in advance.
"Welcome" Outpatient Service Waiver	No "Welcome" Outpatient Service Waiver.	Not applicable.
Annual Deductible	$100 per Member or $200 per family unit per calendar year.	$200 per Member or $400 per family unit per calendar year.
Plan Coinsurance	80% after the annual deductible is satisfied.	70% of the Usual, Customary and Reasonable (UCR) charges are covered after the annual deductible is satisfied.
Lifetime Maximum	$2,000,000 per Member.	$2,000,000 per Member.
Hospital Services Covered inpatient medical and surgical services, including acute chemical withdrawal (detoxification)	Covered at the plan coinsurance after the annual deductible is satisfied.	Covered at the plan coinsurance after the annual deductible is satisfied.
Covered outpatient hospital surgery (including ambulatory surgical centers)	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.
Outpatient Services (Office Visits) Covered outpatient medical and surgical services	Covered at the plan coinsurance after the annual deductible is satisfied.	Covered at the plan coinsurance after the annual deductible is satisfied.
Allergy testing	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.
Oncology (radiation therapy, chemotherapy)	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.

Drugs – Outpatient (including mental health drugs, contraceptive drugs and devices and diabetic supplies) Prescription drugs, medicines, supplies and devices for a supply of thirty (30) days or less when listed in the Group Health Options (GHO) drug formulary	Covered subject to the lesser of the MHCN's charge or a $15 copayment for generic drugs or $30 copayment for brand name drugs.	Covered subject to a $20 copayment for generic drugs or $35 copayment for brand name drugs.
Over-the-counter drugs and medicines	Not covered.	Not covered.
Allergy serum	Covered in full for each thirty (30) day supply.	Covered subject to the applicable prescription drug cost share for each thirty (30) day supply.
Injectables	Injections that can be self-administered are subject to the applicable prescription drug cost share.	Injections that can be self-administered are subject to the applicable prescription drug cost share.
Mail order drugs and medicines	Covered subject to two (2) times the applicable prescription drug cost share for each ninety (90) day supply or less.	Not covered.
Growth hormones	Covered at the plan coinsurance after the annual deductible is satisfied, subject to a twelve (12) month waiting period.	Covered at the plan coinsurance after the annual deductible is satisfied, subject to a twelve (12) month waiting period.
Out-of-Pocket Limit (Stop Loss)	Limited to an aggregate maximum of $1,000 per Member or $2,000 per family per calendar year. Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit:: • Annual deductible • Plan coinsurance • Emergency services at a MHCN Facility • Ambulance services	Limited to an aggregate maximum of $2,500 per Member or $5,000 per family per calendar year. Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit: • Annual deductible • Plan coinsurance • Emergency services at a non-MHCN Facility
Acupuncture	Covered subject to the applicable outpatient services copayment and at the plan coinsurance for self-referrals to a MHCN Provider up to a maximum of eight (8) visits per Member per medical diagnosis per calendar year, after the annual deductible is satisfied. When approved by GHO, additional visits are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.

Ambulance Services Emergency ground/air transport Non-emergent ground/air interfacility transfer	Covered at 80%. Covered at 80% for MHCN-initiated transfers, except hospital-to-hospital ground transfers covered in full.	Covered at 80%. When Medically Necessary and prescribed by the attending physician, transport from one medical facility to the nearest facility equipped to render further Medically Necessary treatment is covered at 80%. Services are not subject to annual deductible. Coinsurance does not apply to the out-of-pocket limit.
Chemical Dependency Inpatient Services	Covered subject to the applicable inpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered at the plan coinsurance after the annual deductible is satisfied.
Outpatient Services	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.
Benefit Period Allowance	$13,000 maximum per Member per any twenty-four (24) consecutive calendar month period. Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.	$13,000 maximum per Member per any twenty-four (24) consecutive calendar month period. Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.
Devices, Equipment and Supplies (for home use) Covered items include: • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras [limited to two (2) every six (6) months] • Ostomy supplies • Prosthetic devices	Covered at 80%. Covered at 80%.	Covered at 80% after the annual deductible is satisfied. Covered at 80% after the annual deductible is satisfied.
Diabetic Supplies	Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit. Blood glucose monitoring reagents and urine-testing reagents are covered in full.	Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit. Blood glucose monitoring reagents and urine-testing reagents are covered at the plan coinsurance after the annual deductible is satisfied.
Diagnostic Laboratory and Radiology Services	Covered at the plan coinsurance after the annual deductible is satisfied.	Covered at the plan coinsurance after the annual deductible is satisfied.

Emergency Services	Covered subject to a $75 copayment per Member per emergency visit at a MHCN Facility, then covered at the plan coinsurance after the annual deductible is satisfied. Copayment is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services cost share.	UCR charges are covered at 80%, subject to a $75 deductible per Member per emergency visit at a non-MHCN Facility (world-wide), after the annual deductible is satisfied. Deductible is waived if Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services cost share. The Member must notify GHO within twenty-four (24) hours following admission and agree to have care managed by the MHCN in order to have inpatient services covered under the MHCN benefit level. If the Member does not notify GHO within twenty-four (24) hours following admission, or declines to have care managed by the MHCN, all inpatient services are covered at the plan coinsurance after the annual deductible is satisfied.
Hearing Examinations and Hearing Aids	Hearing examinations to determine hearing loss are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. Hearing aids, including hearing aid examinations and fittings, are covered up to a $400 maximum per ear limited to one (1) aid per ear during a period of three (3) consecutive years.	Hearing examinations to determine hearing loss are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. Hearing aids, including hearing aid examinations and fittings, are covered up to a $400 maximum per ear limited to one (1) aid per ear during a period of three (3) consecutive years.
Home Health Services	Covered in full. No visit limit.	Covered at the plan coinsurance after the annual deductible is satisfied.
Hospice Services	Covered in full.	Covered at the plan coinsurance after the annual deductible is satisfied.
Infertility Services (Including Sterility)	General diagnostic services are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. Specific diagnostic services, treatment, and outpatient prescription drugs are covered at 50% of the total charges. Diagnosis or treatment of sexual dysfunction is not covered.	General diagnostic services are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. Specific diagnostic services and treatment are covered at 50% of the total charges after the annual deductible is satisfied. Outpatient prescription drugs are covered at 50% of the total charges. Diagnosis or treatment of sexual dysfunction is not covered.
Manipulative Therapy	Covered subject to the applicable outpatient services copayment and at the plan coinsurance for self-referrals to a MHCN Provider for manipulative therapy of the spine up to a maximum of twenty (20) visits per Member per calendar year, after the annual deductible is satisfied. When approved by GHO, additional manipulation visits are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance for manipulative therapy of the spine or extremities up to a maximum of twenty (20) visits per Member per calendar year after the annual deductible is satisfied.

Maternity and Pregnancy Services Delivery and associated hospital care	Covered subject to the applicable inpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered at the plan coinsurance after the annual deductible is satisfied.
Routine prenatal and postpartum care	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.
Mental Health Services Inpatient services	Covered subject to the applicable inpatient services cost share for up to twelve (12) days per Member per calendar year at a GHO-approved mental health care facility. Coinsurance applies to the out-of-pocket limit.	Covered subject to the applicable inpatient services cost share for up to twelve (12) days per Member per calendar year. Coinsurance applies to the out-of-pocket limit.
Outpatient services	Covered subject to the applicable outpatient services cost share for up to twenty (20) visits per Member per calendar year. Coinsurance applies to the out-of-pocket limit.	Covered subject to the applicable outpatient services cost share for up to twenty (20) visits per Member per calendar year. Coinsurance does not apply to the out-of-pocket limit.
Naturopathy	Covered subject to the applicable outpatient services copayment and at the plan coinsurance for self-referrals to a MHCN Provider up to a maximum of three (3) visits per Member per medical diagnosis per calendar year, after the annual deductible is satisfied. When approved by GHO, additional visits are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.
Optical Services Routine eye examinations	Covered in full once every twelve (12) months, except as Medically Necessary. Not subject to the annual deductible or plan coinsurance. Eye examinations for eye pathology are covered subject to the applicable outpatient services copayment and at the plan coinsurance as often as Medically Necessary.	Covered up to $50 once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are subject to the applicable outpatient services copayment and at the plan coinsurance as often as Medically Necessary after the annual deductible is satisfied.
Lenses, including contact lenses, and frames	Eyeglass lenses and frames; or contact lenses, including exams associated with their fitting, covered up to $150 per Member in any consecutive twenty-four (24) month period.	Eyeglass lenses and frames; or contact lenses, including exams associated with their fitting, covered up to $150 per Member in any consecutive twenty-four (24) month period.
Organ Transplants	Covered subject to the applicable cost share up to a $200,000 lifetime benefit maximum.	Covered subject to the applicable cost share up to $200,000 lifetime benefit maximum. Transplant services must be received at a facility authorized in advance by GHO.
Pre-Existing Condition	Covered subject to the applicable cost share, with no wait.	Covered subject to the applicable cost share, with no wait.

Preventive Services (Well adult and well child physicals, immunizations, pap smears, mammograms)	Covered in full when in accordance with the well-care schedule established by GHO. Not subject to any cost-shares. Excluded are physicals for travel, employment, insurance, license, etc. Services provided during a preventive care visit which are not in accordance with the well-care schedule are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered at the plan coinsurance up to a $150 maximum per Member ($300 per family) per calendar year. Routine mammography services are covered at the plan coinsurance after the annual deductible is satisfied. Excluded are physicals for travel, employment, insurance, license, etc.
Rehabilitation Services Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under	Covered subject to the applicable inpatient services copayment and at the plan coinsurance for up to sixty (60) days per condition per calendar year, after the annual deductible is satisfied.	Covered at the plan coinsurance for up to sixty (60) days per condition per calendar year, after the annual deductible is satisfied.
Outpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under	Covered subject to the applicable outpatient services copayment and at the plan coinsurance for up to sixty (60) visits per condition per calendar year, after the annual deductible is satisfied.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance for up to sixty (60) visits per condition per calendar year, after the annual deductible is satisfied.
Skilled Nursing Facility (SNF)	Covered at the plan coinsurance up to sixty (60) days per Member per calendar year, after the annual deductible is satisfied.	Covered at the plan coinsurance up to sixty (60) days per Member per calendar year, after the annual deductible is satisfied.
Sterilization (vasectomy, tubal ligation)	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. Procedures to reverse a sterilization are not covered.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. Procedures to reverse a sterilization are not covered.
Temporomandibular Joint (TMJ) Services Inpatient and outpatient TMJ services Lifetime benefit maximum	Covered subject to the applicable copayment and at the plan coinsurance up to a $1,000 maximum per Member per calendar year, after the annual deductible is satisfied. Covered up to $5,000 per Member.	Covered subject to the applicable copayment and at the plan coinsurance up to a $1,000 maximum per Member per calendar year, after the annual deductible is satisfied. Covered up to $5,000 per Member.
Tobacco Cessation Individual/group sessions Approved pharmacy products	Covered in full. Covered subject to the lesser of the MHCN's charge or the applicable prescription drug cost share for a supply of thirty (30) days or less of a prescription or refill when prescribed by a MHCN Provider and obtained at a MHCN Facility.	Not covered. Not covered.

Limitations	Coverage for cosmetic services is limited to breast reconstruction following mastectomy, and reconstructive breast reduction on non-diseased breast.	Coverage for cosmetic services is limited to breast reconstruction following mastectomy, and reconstructive breast reduction on non-diseased breast.
Exclusions	Services or programs not provided or authorized by MHCN staff (except as specified); travel medications; investigational or experimental procedures, drugs and devices; dental care; arch supports including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; convalescent or custodial care; cardiac rehabilitation programs; services covered by first-party insurance; services covered by government and military programs; employment, license, immigration or insurance examinations or reports. Unless otherwise noted as covered, the following services are also excluded: diagnostic testing of sterility, infertility or sexual dysfunction; work-related conditions (including self-employment, L&I and worker's compensation).	Travel medications; investigational or experimental procedures, drugs and devices; dental care; arch supports including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; convalescent or custodial care; cardiac rehabilitation programs; services covered by first-party insurance; services covered by government and military programs; employment, license, immigration or insurance examinations or reports. Unless otherwise noted as covered, the following services are also excluded: diagnostic testing of sterility, infertility or sexual dysfunction; work-related conditions (including self-employment, L&I and worker's compensation); routine eye examinations; most preventive care services.